CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

The Commonwealth of Massachusetts
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Secretary

MARGRET R. COOKE
Acting Commissioner

Tel: 617-624-6000
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Individual Therapist/Treatment Provider Report

Please complete and return this Report as stipulated in the Consent Agreement for SARP Participation (CASP).

Name of Participant in SARP (please print):_____

Frequency of therapy sessions:

[ ] Weekly [ ] Bi-weekly [ ] Monthly [ ] PRN [ ] Other:_____

Dates of sessions attended since last Report:

Dates

Dates of sessions missed since last Report:

Date	**Reason for Absence**

1 . Have you read the Participant's Consent Agreement for SARP Participation (CASP)?

Comments: _____

2. Is the Participant making satisfactory progress? [ ] Yes [ ] No [ ] Unsure

Comments: _____

3. Have there been any breaks of abstinence since the last Report? [ ] Yes [ ] No [ ] Unsure

Comments: _____

4. New or Additional Compliance Concerns Since Last Report: ___[ ] None_____

_____

_____

_____

****

Name of Therapist/Counselor (please print) _____

License#/Registration#/Certification#: _____

Agency:_____Telephone: _____

E Mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Degree(s):_____Date(s) received: _____

Length of time in practice: _____

Are you a Certified Chemical Dependency Counselor [ ] Yes [ ] No

Type of Certification: _____ Date received: _____

Signature of Therapist/Counselor **Date of Report**